

Washington Rural Health Quality Network Field Test
ER Transfer Tool

Hospital Name: _____ **Hospital Medicare #:** _____

Provider Name: _____ **Provider Medicare #:** _____

Patient's First Name: _____ **Patient's Last Name:** _____

ICD-9-CM Principal Diagnosis Code: _____ . _____

ICD-9-CM Other Diagnosis Code

_____ . _____ _____ . _____ _____ . _____

_____ . _____ _____ . _____ _____ . _____

_____ . _____ _____ . _____

DOB: _____ / _____ / _____

Race:
(*Select one*)

_____ Black or African American
_____ American Indian/Alaska Native
_____ Asian
_____ White
_____ Native Hawaiian/Pacific Islander
_____ UTD

Sex: _____ Male _____ Female

Zip Code: _____

Medical Record #: _____

**Hispanic
Ethnicity:**

_____ Yes
_____ No/UTD

Social Security #: _____

Medicare/HIC #: _____

Payment Source:
(*Select all that
apply*)

_____ Medicare
_____ Medicaid
_____ Other (e.g., Veteran Administration (VA), CHAMPUS, Workers' Compensation,
or private insurance)
_____ No insurance/Not documented/UTD

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Admission Source

(Select one option)

- | | |
|---|--|
| <p>_____ 1 = Physician referral</p> <p>_____ 2 = Clinic referral</p> <p>_____ 3 = HMO referral</p> <p>_____ 4 = Transfer from a hospital STOP
ABSTRACTION</p> <p>_____ 5 = Transfer from skilled nursing facility</p> | <p>_____ 6 = Transfer from another health care facility</p> <p>_____ 8 = Court/law enforcement</p> <p>_____ 9 = Information not available</p> <p>_____ A = Transfer from a critical access hospital
STOP ABSTRACTION</p> <p>_____ B = From home</p> |
|---|--|

Did the Patient arrive by ambulance?

- _____ Yes
- _____ No

Arrival date: ____ / ____ / ____

Arrival time: ____ (military time)

Discharge date: ____ / ____ / ____

Discharge time: ____ (military time)

Discharge Status

(Select one option)

- _____ 01 = Discharged to home care or self care (routine discharge)
- _____ 02 = Discharged/transferred to another short term general hospital for inpatient care
- _____ 03 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification
- _____ 04 = Discharged/transferred to an intermediate care facility (ICF)
- _____ 05 = Discharged/transferred to another type of institution for inpatient care
- _____ 06 = Discharged/transferred to home under the care of organized home health service organization
- _____ 07 = Left against medical advice or discontinued care
- _____ 08 = Discharged/transferred to home under care of home IV provider
- _____ 09 = Admitted as an inpatient to this hospital
- _____ 20 = Expired
- _____ 41 = Hospice patients who expired in a medical facility such as hospital, SNF, ICF or freestanding hospice
- _____ 43 = Discharged/transferred to a federal health care facility
- _____ 50 = Hospice – home
- _____ 51 = Hospice - medical facility
- _____ 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing bed
- _____ 62 = Discharged/transferred to an inpatient certified rehabilitation facility (IRF) including rehabilitation distinct units of a hospital
- _____ 63 = Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- _____ 64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- _____ 65 = Discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital

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- 1. Does Medical Record documentation indicate that there was nurse to nurse communication prior to the transfer of the patient from the ER to another facility?**

_____ Yes
_____ No

- 2. Does Medical Record documentation indicate that there was physician to physician communication prior to the transfer of the patient from the ER to another facility?**

_____ Yes
_____ No

- 3. Does Medical Record documentation indicate that the name of the receiving hospital involved in the transfer is documented in the chart?**

_____ Yes
_____ No

For the remaining questions ‘sent’ refers to medical record documentation that indicates information either went with the patient or was communicated to the receiving hospital with/in 60 minutes of departure.

- 4. Does Medical Record documentation indicate that patient information including name, address, age, gender was sent with the patient?**

Name	Yes__	No__	NA__
Address	Yes__	No__	NA__
Age	Yes__	No__	NA__
Gender	Yes__	No__	NA__

- 5. Does Medical Record documentation indicate that contact information for significant other and/or family member was sent with the patient?**

_____ Yes
_____ No
_____ NA

- 6. Does Medical Record documentation indicate that insurance information was sent with the patient?**

_____ Yes
_____ No
_____ NA

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7. Does Medical Record documentation indicate that vital signs taken and were sent with the patient?

a. Pulse	Yes__	No__	
b. Resp	Yes__	No__	
c. BP	Yes__	No__	
e. O2 Sat	Yes__	No__	
f. Temp	Yes__	No__	NA __

8. Does Medical Record documentation indicate that other assessments were done, as appropriate, and sent with the patient?

a. Glasgow Coma Scale or neuro flow sheet	Yes__	No__	NA__
b. APGAR	Yes__	No__	NA__

9. Does Medical Record documentation indicate that the following physician communications were sent with the patient?

a. History and Physical	Yes__	No__
b. Reason for transfer or Plan of care	Yes__	No__

10. Does Medical Record documentation indicate that the following nursing communications were sent with the patient?

a. Medication History	Yes__	No__	NA__
b. Allergies and reactions	Yes__	No__	NA__
c. Impairments	Yes__	No__	NA__
d. Comprehensive nurses notes	Yes__	No__	NA__

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11. Does Medical Record documentation indicate that information was sent on the treatment provided in the originating hospital?

a. Medication Administration Record	Yes__	No__	NA__
b. Catheters	Yes__	No__	NA__
c. Oral restrictions (NPO etc)	Yes__	No__	NA__
d. Immobilizations	Yes__	No__	NA__
e. Respiratory support provided	Yes__	No__	NA__

12. Does Medical Record documentation indicate that information was sent on the tests and procedures that were done in the ER?

____ Yes
____ No
____ NA

13. Does Medical Record documentation indicate that the results from completed tests and procedures were sent with the patient?

____ Yes
____ No
____ NA